submitted claim is received with a service and locality listed in Addendum D, and a service that is not listed in Addendum D, both charges would be processed with the ten (10) percent reduction applied to the service that is not listed in Addendum D. The waiver is to be granted under limited circumstances. The provider is required to file the claim for the beneficiary. If the provider files for a procedure that is not in Addendum D, then the provider is expected to file for the procedure that is in Addendum D. Granting of a waiver using Addendum D should not be used as an automated process, but used on an individual case basis when a beneficiary files a claim and the provider refuses to submit the claim. If the procedure is not found in Addendum D, the contractor should apply the following criteria before denying the waiver. The criteria is as follows:

(a) Primary care which exceeds thirty (30) minutes from home to the delivery site.

(b) Specialty care which exceeds one hour from home to the delivery site.

(2) The requirement that providers submit claims is waived with respect to all providers (participating and nonparticipating) who reside outside of the United States and Puerto Rico. The requirement shall be waived in cases where the beneficiary has other health insurance which provides primary coverage for the services. Primary by definition would normally lead to payment by the other health insurance, but not just for deductible or for specific denied services. When there is other health insurance that is primary to TRICARE, regardless of whether the OHI covers all procedures on a claim, a waiver to the provider filing of the claim requirement is to be granted. Termination of the other health insurance would mean that the waiver shall be withdrawn by the contractor and the beneficiary shall no longer be responsible for submitting claims. When a waiver is granted to a nonparticipating provider by the contractor, the beneficiary is then responsible for submitting future claims. Waiver denials of the requirement for providers to submit claims are not subject to the appeals process even though a waiver was not granted. A EOB shall be sent to a nonparticipating provider even though a waiver was granted. The conditions for a waiver are to be considered individually although more than one waiver condition may come into play.

d. Noncompliance

(1) Repeated failure by a provider to comply with the claim submittal requirement shall be considered abuse and is grounds for exclusion or suspension of the provider from TRICARE. Repeated means more than once; however, documented three infractions and documented provider contact of the infractions would definitely be grounds for a Program Integrity referral. (See OPM Part Two, Chapter 7). If an administrative fee *for filing a claim or supplying other information* is filed after a claim is processed, the contractor shall deny the charge. No adjustment to the processed claim is necessary. However, the provider should be flagged.

(2) When the contractor receives a claim submitted by a beneficiary, the contractor shall question the reason why the beneficiary is submitting the claim. The contractor shall question the reason does not mean the contractor is to develop,

but simply that a potential problem may exist. The contractor shall process the claim, and contact the provider advising him/her of the claims submittal requirement and advise the provider that any further claims provided to *TRICARE* beneficiaries must be submitted on behalf of the beneficiary. The contractor has the latitude to determine the most cost effective means for warning a provider, e.g., EOB, letter, etc. The provider contact is to be documented, but it does not matter how the contact is made. Notifying the provider of the filing requirement using the EOB is acceptable. In addition, the provider shall be informed that the 10% reduction in the amount allowed cannot be billed to the beneficiary. The contractor is required to annotate history as to who filed the claim. The contractor is required to flag the provider file to identify noncompliant providers. All provider contact shall be documented as backup for possible future suspension or exclusion by *TRICARE*. In addition, the Contractor's Program Integrity Department shall follow the instructions in the OPM Part Two, Chapter 7, Section V. Repeated failure by a provider to comply with the claim submittal requirement shall be considered Program abuse and is grounds for exclusion or suspension of the provider from *TRICARE* pursuant to *32 CFR 199.9*. When a claim is submitted by a beneficiary and the allowable charge is reduced by 10%, the provider could resubmit the claim as long as the original claim filed by the beneficiary is not processed. If the provider submits a claim that is returned uncontrolled for provider signature and in the interim the beneficiary submits the same claim which is processed to completion and reduced by 10% with the provider resubmitting the signed claim which is processed to completion and denied as a duplicate, the contractor is required to adjust the paid claim to remove the 10% reduction, since the provider clearly did make an effort to submit the claim.

(3) When a provider refuses to file on behalf of the beneficiary; when there is no access problem found by the contractor (the services have been rendered); and when the beneficiary has already paid the provider, the claim from the beneficiary on a case-by case basis will be processed. The contractor is to advise the beneficiary of the filing requirement by the provider and instruct the beneficiary of the outcome.

e. Publicity

(1) Through a one time mailing to all professional providers (including professional providers of institutions, portable x-ray companies, durable medical equipment and medical supply firms, mammography suppliers, independent laboratories, ambulance companies, and authorized providers of a Home Health Agency), contractors shall notify them that beginning October 1, 1996, providers are required to complete and submit all claims (both participating and nonparticipating) for *TRICARE* beneficiaries. Contractors shall also notify providers and beneficiaries by stuffers and quarterly news bulletins at a mutually agreed-upon time between the contractor and the Contracting Officer and shall continue to send reminders for at least two full quarters. The messages are provided below. Contractors may add additional information subject to the approval of the Operations Directorate. Stuffers are sent to beneficiaries and the quarterly, regularly required news bulletins are to be sent to authorized TRICARE providers including nonparticipating providers that are on the contractor's provider file.

(a) Message for one time mailing to all professional providers

(b) Beginning October 1, 1996, providers must complete and submit all claims for *TRICARE* beneficiaries

(2) For services provided to *TRICARE* beneficiaries on and after October 1, 1996, all claims (both participating and nonparticipating) shall be completed and submitted by the provider to the contractor for payment. Providers may decide on a claim by claim basis whether or not they wish to participate. The provider may NOT bill the beneficiary a fee for filing the claim form. If the provider fails or refuses to submit the claim or charges an administrative fee for filing the claim, the allowable amount of the claim shall be reduced by a 10% abatement. The provider may NOT bill the beneficiary for this reduction. Repeated failures or refusals by a provider to comply with the claim submittal requirement shall be considered abuse and is grounds for exclusion or suspension of the provider from the *TRICARE* Program. For beneficiaries with other health insurance that provides primary coverage for the services, a waiver to this requirement shall be granted.

(a) Message for stuffers and news bulletins

(b) Beginning October 1, 1996, providers must complete and submit all claims for *TRICARE* beneficiaries

(3) For services provided on and after October 1, 1996, all claims must be completed and submitted by the provider to the contractor for payment. The provider may NOT charge a fee for filing your claim forms. If the provider fails or refuses to submit the claim or charges an administrative fee for filing the claim, the allowable amount of the claim will be reduced by a 10% abatement. Your provider may NOT bill for this 10% reduction. An administration fee is not payable by the beneficiary. If the provider refuses to submit the claim, the beneficiary is to complete a claim form and send it to **{name of contractor}** along with a letter explaining that the provider will not submit claims and requesting a waiver of this requirement. If a waiver is granted, the beneficiary will be responsible for submitting all future claims from this provider. If the waiver is not granted, the provider may be excluded or suspended from the *TRICARE* Program. For beneficiaries with other health insurance that provides primary coverage for the services, a waiver to this requirement will be granted. When a claim is submitted with a waiver request, the claim shall receive special attention by the contractor. The claim shall be processed subject to contacting the provider and making a waiver determination.

NOTE to the CONTRACTOR:

A EOB message cannot be substituted for the stuffer. When a waiver is granted, the contractor will send a copy of the EOB to the nonparticipating provider for balance billing. EOBs are to be sent to each provider on the claim. In addition to this one time mailing, the contractor shall include a similar message with the EOB sent to the provider. Stuffers are to be sent to beneficiaries. The language may be modified for the provider bulletins, but still conveying the same message. When a claim is submitted with a waiver request, the claim shall be controlled. The claim shall be processed subject to contacting the provider to determine the reason for not submitting the claim prior to making a waiver determination.

f. Participating Provider - Agency Agreement with a Third Party

Occasionally, a participating provider may enter into an agency agreement with a third party to act on its behalf in the submission and the monitoring of

third party claims, including *TRICARE* claims. Such arrangements are permissible as long as the third party is not acting simply as a collection agency. There must be an agency relationship established in which the agent is reimbursed for the submission and monitoring of claims, but the claim remains that of the provider and the proceeds of any third party payments, including *TRICARE* payments, are paid to the provider. The contractor can deal with these agents in much the same manner as it deals with the provider's accounts receivable department. However, such an entity is not the provider of care and cannot act on behalf of the provider in the filing of an appeal unless specifically designated as the appealing party's representative in the individual case under appeal. Questions relating to the qualifications of any such business entity should be referred to the *TMA* Office of General Counsel for resolution.

C. Foreign Claims

Refer to the OPM Part Two, Chapter 22 for the requirements for processing Foreign claims.

D. Pricing Supplemental Health Care Program (SHCP) Claims

Refer to the OPM Part Two, Chapter 10 for the requirements for pricing claims received under the SHCP.

E. *TRICARE* Claim Forms

Normally benefits may not be extended under the *TRICARE* Basic Program or Program for Persons with Disabilities (PFPWD) unless a properly completed claim form is submitted.

1. Responsibility for Completing a Claim

The *TRICARE* beneficiary or the participating provider is responsible for completing a claim. Neither a *TRICARE* contractor nor *TMA* is authorized to prepare a claim on behalf of a beneficiary. However, contractors shall assist providers and beneficiaries whenever possible. (See Section V., of this chapter, for procedures to develop required information.)

2. Right to Information

TMA and *TRICARE* contractors may request from the provider of the services or supplies or the beneficiary any information necessary for the accurate and efficient administration of requested benefits. Failure to provide the requested information may result in denial. *TMA* and the *TRICARE* contractor shall hold the information confidential except when:

a. Disclosure is specifically authorized by the beneficiary

b. Disclosure is necessary to permit authorized government officials to investigate and prosecute criminal actions

c. Disclosure is specifically authorized or required under the terms of the Privacy Act or Freedom of Information Act. *TMA* and *TRICARE* contractors may, without consent or notice to a beneficiary, release to or obtain from any insurance company

or other organization, governmental agency, provider or person any information with respect to any beneficiary when such release constitutes a routine use duly published in the **Federal Register** in accordance with the Privacy Act (5 U.S.C. 522a).

3. Acceptable Claim Forms

The following claim forms are approved for use in filing for *TRICARE* benefits: The DD Form 2520, the DD Form 2642, the HCFA 1500/CHAMPUS 501, the UB-92, and the UBF-1-81 (which is acceptable only from institutional providers in the State of New York). Electronic Media Claims (EMC) that meet all *TRICARE* requirements for payment are also acceptable. See definition for "claim form" in *the* OPM Part Two, Chapter 11.

NOTE:

With the exception of claims for institutional services submitted on Forms UB-92, which must be submitted by the participating provider, contractors shall process a claim submitted by a beneficiary on any of the approved forms even if for services other than those for which the form is designated. The contractor shall not return such claims for resubmission on an appropriate form. Any information required for processing but not submitted with the claim shall be obtained in accordance with the procedures in Section V. of this chapter. Claims from providers shall be accepted only on the appropriate claim forms. See Section IV.A.2. for instructions concerning non-TRICARE claims. ***Exception****: Refer to Policy Manual, Chapter 13, Section 12.1.*

a. DD Form 2642, "Patient's Request for Medical Payment," (Figure 2-1-A-21)

This form is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care. Those include physicians, pharmacies, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Program for Persons with Disabilities providers, vendor pharmacies, or other authorized providers. If a DD Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned uncontrolled to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the HCFA 1500 or the UB-92, whichever is appropriate. The new form may be used for services provided in a foreign country but only when submitted by the beneficiary. The DD Form 2520 will continue to be used by foreign providers and by beneficiaries receiving medical care in foreign countries. Contact the *TMA* Administrative Services Branch to order the DD Form 2642.

NOTE:

The following is required for six months and shall begin at a mutually agreed-upon time between the FI and the Contracting Officer.

NOTE:

Message for EOB Stuffer:

TRICARE is replacing the standard CHAMPUS form (yellow), DD Form 2520, with a new beneficiary form (white), the "Patient's Request for Medical

Payment," DD Form 2642. Enclosed is a copy for your future use. The new form is solely for the use of beneficiaries and may not be used by providers of care for submitting TRICARE claims.

Please immediately use any DD Forms 2520 that you may have in stock. After December 31, 1995, the DD Form 2520 will not be accepted for the payment of medical care obtained in the United States or Puerto Rico. The DD Form 2520 will continue to be used either by your provider or yourself for the billing of services in foreign countries, or you may use the new form.

Providers completing or filing claims for TRICARE beneficiaries in the United States and Puerto Rico should begin to bill TRICARE on the HCFA 1500, or the UB-92, whichever is appropriate. Beginning January 1, 1996, all providers rendering care in the United States and Puerto Rico will be required to use either the HCFA 1500 or the UB-92.

b. Department of Defense Form 2520, *TRICARE*/CHAMPVA Claim Form (Figure 2-1-A-1)

(1) This form may be used to submit a claim requesting payment for either inpatient or outpatient professional services or supplies furnished by civilian sources, under the standard *TRICARE* program, the PFPWD or prescription drug claims. The form can be submitted by either a beneficiary or provider of care. This is the form of choice when the claimant is attaching copies of bills and receipts. Ordinarily, a provider who is submitting the DD Form 2520 would complete the lower portion of the form, whether participating or not.

(2) The DD Form 2520 is being discontinued for use in the United States and Puerto Rico. When current stocks are depleted, no DD Forms 2520 will be supplied except for medical care or supplies provided outside of the United States and Puerto Rico. Requests from providers for DD Forms 2520 shall not be honored and providers will be informed that they are to use the HCFA 1500 or the UB-92 for all *TRICARE* billings. After December 31, 1995, no DD Form 2520s will be accepted for processing except for services rendered in foreign countries.

(3) *Contractors* shall notify affected providers that *TRICARE* is discontinuing the DD Form 2520. *Contractors* shall notify providers by provider news bulletin of this change. The message is provided below. *Contractors* may add additional information subject to the approval of the Program Administration Branch

NOTE:

Message for Provider News Bulletin:

TRICARE is replacing the TRICARE Form 2520 with a new beneficiary form, the "Patient's Request for Medical Payment," DD Form 2642. The new form is solely for the use of beneficiaries and may not be used by providers of care for submitting TRICARE claims.

Please use immediately any DD Forms 2520s that you may have in stock. After December 31, 1995, the DD Form 2520 will not be accepted for the reimbursement of medical care rendered in the United States or Puerto Rico. Please bill TRICARE on either the HCFA 1500 or the UB-92, whichever is

appropriate. However, a DD Form 2520 will still be required for providers billing for services rendered in foreign countries.

Please support the military, their active duty family members, and the retirees and their family members by submitting your bill for them. We encourage you to participate (accept assignment) under TRICARE. Participation may be on a case-by-case basis or you may contact the nearest military treatment facility (MTF) or ***(contractor point of contact)*** *for information concerning full-time participating provider programs. Even if you do not choose to be a TRICARE participating provider, TRICARE requests that you complete and submit either the Form HCFA 1500 or the UB-92 for the TRICARE beneficiary. Remember if you do not participate, payment will go directly to the beneficiary.*

c. Health Insurance Claim Form, Form HCFA 1500 (Figure 2-1-A-2), Revised 12-90

(1) The Form HCFA 1500 is a national standard claim form designed for use by individual professional providers of medical care (psychologists, dentists, pharmacists, marriage counselors, suppliers, etc.) or by institutions billing professional services, or for ambulatory surgical services (for both facility and/or professional charges) performed in authorized freestanding ambulatory surgical facilities or hospital outpatient settings (e.g., a clinic, ambulatory surgery center, or emergency room). Contractors, however, shall process this form if completed by a beneficiary. The 1984 form (or earlier versions) is acceptable through December 31, 1992. After December 31, 1992, only the revised HCFA 1500 dated "12-90", Figure 2-1-A-2, or later shall be accepted (regardless of the service date). Note that the CHAMPUS 501 designation has been removed from the "12-90" form.

(2) If a beneficiary submits a DD Form 2520 with an obsolete 1500 attached as a bill, the contractor shall process the claim if otherwise appropriate. If a provider submits an obsolete HCFA 1500 attached to a DD Form 2520, it shall be returned.

(3) The contractor shall notify affected providers that TRICARE will no longer accept versions of the HCFA 1500 dated prior to December 1990. Contractors shall begin notifying providers by stuffer and provider newsbulletin at a mutually agreed-upon time between the contractor and the Contracting Officer. The messages are provided below. Contractors may add additional information subject to the approval of the Coordinated Care Branch.

NOTE:

Message for Provider Stuffer and Newsbulletin:

TRICARE will not accept obsolete versions of the HCFA 1500/CHAMPUS 501 claim form after December 31, 1992. Obsolete forms are those dated prior to December 1990. We recommend that you begin using the revised "red-on-white-colored" "HCFA 1500 dated "12-90" or later as soon as you exhaust your current stock of the obsolete form. If a claim is submitted on an obsolete form after December 31, 1992, it will be returned with a message advising you that the form is obsolete and must be resubmitted on a December 90 or later version of the form. Although the revised Form HCFA 1500 (12-90) no longer contains the "CHAMPUS 501" designation, the Form HCFA 1500

remains the proper billing form for all individual professional provider and supplier services, to include institutional-based professional providers. If you have not received TRICARE instructions for completing the revised form, contact ***(Contractor Name)****.*

We encourage you to support the military, their active duty family members, and the retirees and their family members by participating (accepting assignment) under TRICARE. Participation may be on a case-by-case basis or you may contact the nearest military treatment facility (MTF) or contractor point of contact for information concerning full-time participating provider programs. If you do not choose to be a TRICARE participating provider, TRICARE requests that you complete and submit the revised Form HCFA 1500 for the TRICARE beneficiary. Please sign and date the claim in Block 31 and check "No" in Block 27 indicating that you are declining to participate. In this case, payment will go directly to the beneficiary. If you choose to be a TRICARE participating provider, please check "yes" in Block 27 indicating you do wish to participate (no prior notice or application is required for standard TRICARE). Sign and date the claim in Block 31. Payment will be sent directly to you. If you do not indicate "yes" or "no" in Block 27, payment will be sent to the beneficiary.

NOTE:

Message for returning obsolete claim forms after December 31, 1992

(PROVIDER OR BENEFICIARY SUBMITTED)

We are returning your claim because it was submitted on an obsolete HCFA 1500 claim form. We regret this inconvenience; however it was necessary for the Health Care Financing Administration (HCFA) to obsolete the older versions of the form and TMA as well as other third party payers agreed to support this action. TRICARE, however, allowed an additional seven months for acceptance of the obsolete forms in order to widely publicize to TRICARE providers that the obsolete form would not be accepted after December 31, 1992. This information was provided in contractor newsbulletins and in TRICARE newsletters. Please resubmit your claim on a current HCFA 1500 which must be dated December 1990 or later.

TRICARE BENEFICIARIES, PLEASE NOTE:

Your claim has been returned because it was submitted on an obsolete HCFA 1500. The DD Form 2642 is provided for your use when your provider or supplier will not complete a HCFA 1500 or UB-82 UB-92, for you. We will, however, accept and process the HCFA 1500 that you have submitted if it is otherwise complete and attached to a completed DD Form 2642. In the future, TRICARE requests that you use the DD Form 2642 which you may obtain from Health Benefit Advisors or Contractor Service Center at or near Military Treatment Facilities, from ***(Contractor Address)*** *or from TMA, Forms Management, Aurora, Colorado 80045-6900.*

(4) If contractors are aware that the obsolete HCFA 1500 is being returned to a beneficiary, the contractor shall include a DD Form 2642 with the returned claim.

d. Form UB-82, Uniform Institutional Billing Form (Figure 2-1-A-3)

The UB-82 is to be used by institutional providers of care for the billing of inpatient and outpatient institutional services, including RTC and PFPWD institutional services. It cannot be used by hospitals to bill for the services of institutional-based professionals or for any individual professional charge or service that requires payment based on the *TRICARE* allowable charge methodology. These charges must be billed on the HCFA 1500 or the CHAMPUS DD Form 2520. Under the standard *TRICARE* mental health per diem payment system, the UB-82 cannot be used to bill hospital professional services for higher volume hospitals and units which are required to bill separately for these services. (See Policy Manual, Chapter 13, Section 6.5.) The data elements and design of the form were determined by the National Uniform Billing Committee (NUBC) and no contractor on its own may modify any data element. The National Uniform Billing Data Element Specifications provide the instructions for the completion of the UB-82. For claims from institutions in the State of New York, the UBF-81 claim form is an acceptable claim form.

e. Form UB-92, Uniform Institutional Billing Form (Figure 2-1-A-20)

(1) This form is to be used by institutional providers of care for the billing of inpatient and outpatient institutional services beginning October 1, 1993. The UB-92 may be used by institutional providers and Home Health Care Agencies to bill for professional services. The UB-92 must include all the required information needed to process the professional services and reimburse the services using the allowable charge payment methodology, to include any negotiated rates. The contractors shall contact any Home Health Care Agency that has requested to bill for professional services on the UB-92 to assist them with the proper billing requirements, e.g., CPT-4 procedure codes, name of the actual provider, etc. The window of time for phasing-out the use of the UB-82 is from October 1, 1993 through March 31, 1994. Both forms shall be accepted during this time frame. After March 31, 1994, only the new form (the UB-92) shall be accepted, no matter what the service date. Institutional claims received after that date on unacceptable claim forms shall be returned uncontrolled with an explanation that the form is no longer acceptable.

(2) After July 1, 1993, contractors shall include a reminder on EOB's to users of the UB-82 that they should begin using the new UB-92 form as soon as it becomes available, and that after March 31, 1994, the UB-82 will not be accepted, regardless of the dates of service. As stated above, this deadline must be published in the next provider newsletter as directed by the Contracting Officer.

(3) Beginning October 1, 1993, all claims processors shall be able to accept, process and report the new *TRICARE* required UB-92 data elements. The ADP Manual changes associated with UB-92 implementation provide the necessary HCSR changes.)

NOTE:

The American Hospital Association (AHA) has completed the National Uniform Billing Data Element Specifications, commonly referred to as the Data Element Dictionary. One copy of the Data Element Dictionary is available for contractor use. This copy may be obtained from the Directives Manager,

Administration Branch, TMA. Do not contact AHA as they will no longer supply the Data Element Dictionary directly to the contractors.

Claims processors will note, once the Data Element Dictionary is received, that TRICARE requires providers to report some information that HCSRs does not currently require until TMA modifies the reporting requirements. Contractors are not required to report this information.

(4) From October 1 through March 31, 1994, the contractor's claims processor's claims processing system must be capable of accepting and processing both the UB-82 and the UB-92.

f. Laser Printed or Pin-Fed Versions of the TRICARE Form

Laser printed or pin-fed and other versions of the TRICARE forms that do not contain the certification and Privacy Act information on the reverse side of the claim form are not to be accepted and technically should be returned to the provider or beneficiary with instructions to file on an approved version of the claim. A provider may file with the contractor a certification that he/she will fully comply with the certification's terms and conditions on the reverse of the claim form. However, in the absence of any indication to the contrary during normal claims receipt and processing, contractors shall assume the proper authorization is on file for processing the claim. In the contractor's quality control audit and program integrity samples, the contractor shall validate through file checks, those claims, which were filed using laser printed, pin-fed or other versions of the TRICARE-approved forms, that the proper authorization was on file at the time the claim was processed. Contractors should remind providers of the requirement for submitting their claims on the correct form or requesting an exception through at least annual notice in routine bulletins or newsletters and at other appropriate times when contracts are made such as renewal of provider participation agreements. The following format shall be incorporated into a letter from an authorized provider representative and kept on file at the contractor:

*"I am the **(Title or Position)**, an authorized representative of **(Name of Provider)**, with the authority to file and certify TRICARE claims on behalf of **(Name of Provider)**."*

*"I have read and understand the terms, certifications, and conditions contained on both sides of TRICARE claim form **(Number of Form)** and certify that **(Name of Provider)** will fully comply therewith in the filing of a participating TRICARE claim."*

4. Procedure Codes

The CPT Coding System shall be expanded to include Level 1: CPT Codes, Level 2: Alpha Character Codes and Level 3: TRICARE Unique Codes. The contractors shall notify the affected providers by Stuffer or Special Message that the coding system is expanded, as stated above. (Reference the ADP Manual, Chapter 2, Addendum F and Addendum I, and ADP Manual, Chapter 6, Addendum A, and the Policy Manual, Chapter 13, Section 23.1.)

5. CHAMPVA Claim Form 10-7959A (Figure 2-1-A-16)

All claims processed by the CHAMPVA Center are required to be submitted on the VA's new claim form, VA Form 10-7959A. This is not an authorized *TRICARE* claim form and the contractor shall not accept the form for any *TRICARE* claims. Refer to Section IV.K. for information regarding the action to take if a claim is received on VA Form 10-7959A.

F. *TRICARE* Outpatient Deductible

1. Effective April 1, 1991, the *TRICARE* deductible for outpatient care increases for retirees and their family members and survivors and the family members of active duty E-5s and above ($150.00 per beneficiary; $300.00 per family; i.e., when two or more family members receive care in any one fiscal year). The current *TRICARE* deductible remains the same only for the family members of **active duty E-4s and below**; ($50.00 per beneficiary; $100.00 per family). Deductibles continue to be based on the fiscal year. See the Policy Manual, Chapter 13, Section 11.1, for policy concerning the increase.

2. The contractor shall query DEERS to determine the deductible category for beneficiaries of active duty sponsors. DEERS override authority is provided if the DEERS pay grade/rank differs from the pay grade reported on the claim. If a higher pay grade is reported on the claim than appears on DEERS, the DEERS value shall be overridden and the higher value used for purposes of claims processing, history and HCSR reporting. If a lower pay grade is reported on the claim than appears on DEERS, and the lower pay grade would make a difference for purposes of applicable deductible, the contractor shall develop for hard copy evidence of the actual (lower) pay grade, such as copies of orders, ID cards, promotion/demotion papers, etc. If the pay grade reported on the claim would not make a difference for purposes of applicable deductible/PFPWD cost share amount, the pay grade reported on the claim (regardless of whether it is higher or lower than the DEERS pay grade) shall be used for purposes of claims processing, history and HCSR reporting. (See the ADP Manual, Chapter 9, Section II.D.) *Contractors are not required to compare claim form information on pay grade/rank against DEERS when the claim does not involve a deductible or PFPWD benefit.* If the pay grade/rank category used by the contractor is alleged by the patient or sponsor, after adjudication of the claim, to have been incorrect, it is the responsibility of the beneficiary or sponsor to prove it is incorrect. If the sponsor or beneficiary can substantiate the correct pay grade; i.e., promotion/demotion papers, the contractor shall use the evidence for application of the appropriate deductible category and notify the sponsor or beneficiary to correct the information on DEERS. When claims have been processed against an incorrect deductible category, the contractor shall follow normal procedures for adjustment processing. If a sponsor is demoted during the fiscal year to the lower deductible category and the $150/$300 deductible has been met (or a portion of that amount), the contractor is not required to refund the amount paid in excess of the reduced deductible.

3. See Section VI.C.2., Deductible Documentation, for excess deductible instruction.

4. Upon direction by the Contracting Officer, the contractor shall publicize this change by adding a message on all EOBs or by including a stuffer with the

EOBs through calendar year 1991. The contractor shall include the stuffer with responses to inquiries, appeals and other correspondence. Beginning with the next provider news bulletin, and continuing through calendar year 1991, the contractor shall publicize the increased deductible requirements. The following message or similar information (subject to *TMA* approval) shall be used:

> *"On April 1, 1991, the fiscal year outpatient deductible for all non active duty personnel and their family members and survivors, and the family members of active duty E-5s and above, will increase to $150.00 for one beneficiary and a maximum of $300.00 for two or more family members. Outpatient care provided on or after April 1, 1991, is subject to the increased deductible. Deductible amounts already applied to satisfy the fiscal year 1991 deductible will be applied toward the increased deductible requirements. Although the deductible increase is effective April 1, 1991, the deductible year has not changed; the deductible year continues to begin with the fiscal year change (October 1).*
>
> *Effective October 1, 1991, you must again meet your deductible requirements for fiscal year 1992. Family members of active duty E-4s and below are not affected by the increase; the deductible amounts remain the same, $50.00 per beneficiary or a maximum of $100.00 for two or more family members. Sponsors/beneficiaries are required to ensure that the proper pay grade/ rank is on the DEERS records."*

NOTE:

The deductible increases does not apply to CHAMPVA beneficiaries. The increase does apply to NATO beneficiaries.

NOTE:

Beneficiaries of active duty members with Persian Gulf conflict service who are, or were, entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310 are temporarily exempt from the deductible increase that became effective April 1, 1991. See the Policy Manual, Chapter 13, Section 11.1. The exemption applies to claims with dates of service on and after April 1, 1991, through September 30, 1991. Beginning October 1, 1991, this exemption will end and the deductible increase will be applicable to beneficiaries whose sponsor's pay grade is E-5 or above. DEERS will provide the Operation Desert Storm Indicator. See the ADP Manual, Chapter 9, Addendum A, Figure 9-A-12.

NOTE:

If an active duty sponsor was involved in Desert Storm, and, prior to September 30, 1991, his/her status changed from active duty to retired, or he/she was killed in the Gulf or died prior to September 30, 1991, he/she and his/her family members were exempt from the increased deductible until October 1, 1991. Any beneficiary eligible for the delayed deductible under the Desert Storm provisions, who during the period April 1, 1991 to September 30, 1991, paid a deductible in excess of the amounts stipulated, shall be entitled to an adjustment of the annual deductible required for 1991. Refer to Policy Manual, Chapter 13, Section 11.1. Contractors shall not search their

records to identify claims for services during this period which may have had excess deductible withheld, however, if the contractor is made aware of such claims, they shall perform the appropriate research and make the necessary adjustments.